dell children's
Ascension

DELL CHILDREN'S AUDIOLOGY

Please have the patient's parent/guardian contact the appropriate office, based on referral reason, for an appointment.

Please include any medical records pertaining to the patient's diagnosis/reason for referral.

***** This section MUST be completed *****

☐ **Basic Audio** > 6 mos old

☐ **Newborn Hearing Screen** If **never** tested at birth & **no** NICU stay

☐ **Non-sedated ABR** 0 – 3 months of age only

☐ **Sedated ABR** w/other procedure?:_____

FROM: _____

PHONE: _____

FAX: _____

APPT. DATE/TIME: _____

FOR DELL CHILDREN'S OFFICE USE

Full Name of Referring Physician: _____ M.D. or D.O.

Diagnosis/Reason for Referral (Check ALL that apply):

□ Decreased hearing
□ Speech delay
□ TM perforation
□ Sudden hearing loss
□ Vertigo/dizziness
□ Adverse effects of medication
□ Otitis/inflammation of ear
□ Unilateral/asymmetric loss
□ Tinnitus
□ Discharge from ear
□ Ear Pain
□ Other _____

Referral sent to:

Dell Children's Medical Group ENT & Audiology

Phone: 512-324-2720 **Fax: 512-324-2724**

Diagnosis/Reason for Referral (Check ALL that apply):

□ Decreased hearing
□ Speech delay
□ Adverse effects of medication
□ Other _____

Referral sent to:

Dell Children's Medical Center - Audiology

Phone: 512-324-0137 **Fax: 512-406-6521**

Patient name:_____ **Date of birth** __ __ / __ __ / __ __

Contact Name: _____ PH#: _____

Current Address: _____

Primary Insurance: _____ ID#: _____

☐ **REQUIRES AUTHORIZATION** ☐ **DOES NOT REQUIRE AUTHORIZATION**

*Auth#:*_____ auth must be obtained prior to DOS (ordering provider's office is responsible for obtaining auth)

IMPORTANT–

YES	NO	
☐	☐	Was patient born premature? How many weeks gestation? _____
☐	☐	Does patient currently have or have history of CMV (Cytomegalovirus)?
☐	☐	Is patient currently on insulin for diabetes?
☐	☐	Does patient have history of respiratory (airway) disorders? _____
☐	☐	Does patient have a trach tube or apnea monitor? (Pulmonologist's Name)
☐	☐	Does patient use an oxygen tank?
☐	☐	Does patient have history of cardiac disorders? _____
☐	☐	Does patient have a Vagal Nerve Stimulator (VNS device)? (Cardiologist's Name)
☐	☐	Does patient have any craniofacial abnormalities?
☐	☐	Does patient have Down Syndrome?

☐ _____ ***Date:***_____ ***Time:*** _____

Physician Signature, Date & Time Stamp Required